OptimaHealth

Hours of Operation (EST) 8 AM to 5:00 PM
Monday through Friday

*__Optima Health Community Care__-submit within 30 days of the date listed on the denial letter

This form is to request Reconsideration of a Denied Preauthorization
Fax completed form and supportive clinical data to:
757-837-4704 or 844-857-6409

Attn: Pre-authorization Reconsideration Specialist
****This form is not used for claims reconsideration****

For reconsideration of denied claims, please visit: http://providers.optimahealth.com/billing

Date Listed on Denial Letter: _____

Please check service(s) type previously denied

☐ Advanced Imaging (MRI/CT/PET) ☐ Genetic Testing ☐ DME/Prosthetics

☐ Inpatient (Pre-Service) ☐ Other ☐ Outpatient Service

Member's Name / Last, First	Member's ID / Policy #	Date of Birth	Today's Date

Requesting Provider (Full Name): _____

The following information is required to process your reconsideration request:

Diagnosis Code(s):_____

Procedure Codes Denied: _____/_____/_____/_____

Additional Clinical Data (**information not submitted with original request**) that you believe supports approval:

IE: Medical Records, Test Results, Medications, Failed Treatments or Therapies, Evidence Based Research

To expedite processing, please **do not include the clinical documents submitted with the original request.

** *You may check the status on Optimahealth.com or by calling Provider Relations at 1-844-512-3172 Option 4*

Person Completing this Form: _____

Phone: _____ / ext.:_____ Fax: _____